Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 – Scenario 6

Doctor's Office
Multiple modifiers and Global Services $0.00 charged

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive in Dallas, TX 72309. Her telephone number is (214) 836-5527 and her social security number is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Dallas, TX 72314. Bagel, Etc.'s telephone number is (214) 472-1462 and their FEIN is 59-7654321.

Bagels, Etc. is insured by Texas Insurance Company, located at 789 Airport Road in Dallas, TX 60606-1234. Texas Insurance Company's telephone number is (312) 555-1470 and its FEIN is 98-7654321. Bagels, Etc. is covered under policy number 147643A472.

- On 09/18/02, Darlene lacerated her left index finger while cutting a bagel. Dr. Richard M. Smith examined her and repaired the lacerated finger.
- On 08/27/03 she returned to Dr. Smith's office for suture removal and at that time Dr. Smith noted a slight infection.
- On 08/29/03 Darlene returned for another follow-up visit for wound re-check.
- On 08/30/03 Darlene returned for a follow-up visit for wound re-check.

Dr. Smith's office, Main Medical, is located at 2700 Medical Drive in Arlington, TX 62311. Main Medical FEIN is 34-5678912, his Texas State license number is MDD0293TX.

- On 09/03/03 Dr. Smith billed patient account number 470077 and forwarded the bill with the unique identification number 123456 to Texas Insurance Company with the following charges:
    - 12001 for DOS 08/27/03 in the amount of $75.00
    - 99202 for DOS 08/27/03 with modifiers 47, 99, 32, QU in the amount of $25.00
    - 99211 for DOS 08/29/03 in the amount of $10.00
    - 99211 for DOS 08/30/03 in the amount of $0.00 because it was global to DOS 08/29/03
    - Total charges billed $110.00

- On 09/06/03 Tex as Insurance Company received the bill from Main Medical
- On 09/10/03 under IC claim number 14000714D, TWCC claim number 98-778642 Texas Insurance Company paid:
    - $75.00 for 12001, DOS 08/27/03
    - $20.00 for 99202 for DOS 08/27/03 using Adjustment Reason Codes W1 and 45
    - $10.00 for 99211, DOS 0829/03
    - $0.00 for 99211, DOS 08/23/04
    - Total paid $105.00

Texas Insurance Company is required to report all medical bill payment information to the Texas Workers' Compensation Commission (TWCC) within 30 days of payments made.

On 08/23/04 Texas Insurance Company sent a transaction to TWCC covering the reporting period of 08/15/04 to 09/15/04. The unique bill number assigned by Texas Insurance Company for Darlene's bill was 111123.

TX 837 – Scenario 6

PLEASE DO NOT STAPLE IN THIS AREA

Texas Insurance Company
789 Airport Road
Austin, TX 60606-1234

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 224-17-3272

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Darlene Davidson

3. PATIENT'S BIRTH DATE MM DD YY: 06 04 69 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bagels, Etc.

5. PATIENT'S ADDRESS (No., Street): 5720 Green Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 234 Main St.

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Dallas STATE: TX

ZIP CODE: 72309 TELEPHONE (Include Area Code): (214) 836-5527

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 72314 TELEPHONE (INCLUDE AREA CODE): (214) 472-1462

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 09 18 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: 32, QU

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 814.2 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
08 27 03	08 27 03	11		12001		1	75 00	1				
08 27 03	08 27 03	11		99202	47 99	1	25 00	1				
08 29 03	08 29 03	11		99211		1	10 00	1				
08 30 03	08 30 03	11		99211		1	0 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 345678912 [X]

26. PATIENT'S ACCOUNT NO.: 470077

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 110 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Richard M. Smith MDD0293TX
09/03/03
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Main Medical
2700 Medical Dr.
Arlington, TX 62311

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Main Medical
2700 Medical Dr.
Arlington, TX 62311

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500